KENNEDY (J.C.)

Why we should Operate Early in Appendicitis.

BY

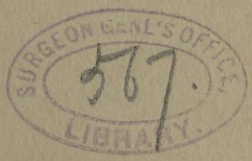
JAMES C. KENNEDY, M. D.,

Visiting Surgeon to St. Mary's and St. Catherine's Hospitals, Brooklyn.

REPRINTED FROM THE

New York Medical Journal

for October 3, 1896.



Reprinted from the New York Medical Journal
for October 3, 1896.

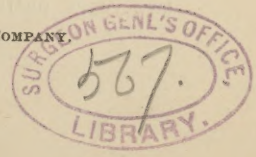
WHY WE SHOULD OPERATE EARLY IN APPENDICITIS.

By JAMES C. KENNEDY, M. D.,
VISITING SURGEON TO ST. MARY'S AND ST. CATHERINE'S HOSPITALS, BROOKLYN.

With many physicians at the present day observations and clinical history seem to argue *pro* and *con* as to when a patient should be submitted to operation, thereby proving their inability to solve the problem.

With a limited experience of cases treated on the expectant plan, and a large experience in operative cases, both in hospital and private practice, I have encountered many varieties of the disease, both in its symptoms and pathology; among others, that rarer pathological condition which is frequently fatal even when combated by the most skillful surgery. I have reference to a diseased appendix, filled with pus, with no plastic adhesions thrown about it whereby the general peritoneal cavity would be protected.

In the early operative history of this disease, as did many of my professional brothers, I struggled amid the troubled billows of distrust, anxiety, and doubt, but I felt that a closer observation of my own cases, as well as a study of the cases of other men, would eventually



bring me to a guiding principle which would direct me in the treatment of cases coming under my care in the future. As a result of these labors I find myself clinging to the teachings of the more radical surgeons, like McBurney, Morris, and others. Hence the following rule: With an empty intestinal tract, localized pain in the right iliac fossa at the McBurney point, the symptoms persisting and increasing for twelve hours, the diagnosis confirmed by exclusion—operate. In doubtful cases—symptoms lasting and increasing longer than twelve or sixteen hours—explore, inspect, remove diseased appendix if found. Men who have experience in operative work in this disease will here call to mind exceptions to this rule, such as extreme obesity, complications of other disease, as valvular disease of the heart, nephritis (acute and chronic).

It may be of some interest to those who would hesitate to have their patients operated on early that I should relate a few cases which I have treated by both methods—surgically and by the expectant plan. Neither in St. Catherine's nor St. Mary's Hospital have any cases, to my knowledge, been treated on the expectant plan, for the reason that all were decidedly operative; but in private practice I have sometimes (in the past) of necessity and sometimes voluntarily treated cases on a strictly expectant or medical plan, some successfully (for the present, at least) and some with the most disastrous effect.

While the patients did not all recover in the operative cases, still I, as well as every one present at the operation, thought that the best chance had been given.

Case I. *Expectant Plan.*—Thomas C., aged twenty-two years, native of this country, theological student.

June 11, 1892.—Complained of pain in the abdomen; bowels constipated. On examination, I found pain diffused over the abdomen, more in left inguinal region; no pain in right iliac fossa over McBurney's point. Temperature, 100°; pulse good. Diagnosis somewhat difficult, but obscure appendicitis kept in mind. Gave castor oil with laudanum, with instruction if the oil did not move the bowels to give a solution of citrate of magnesia.

12th.—No evacuation of the bowels. Magnesia had not been given through mistake; still had slight pain.

13th.—Bowels moved; temperature, 99°; pains very much diminished.

14th.—Felt good, wanted to go down stairs; temperature, 100°; pulse, 94; had not slept much. He was warned to keep as quiet as possible, and under no circumstance to leave his bed.

16th.—After a somewhat restless night he left his bed and began to pace the floor as a sentinel would his beat, when suddenly he felt a pain as if some one had driven a knife into his right inguinal region. His piercing shrieks brought his friends to his side, who found him leaning against the wall with both hands firmly pressed against the McBurney point. He was carefully removed to his couch, when his ghastly countenance told that something was very wrong. I was hastily summoned and arrived at 5 A. M., and found him suffering from severe shock. Temperature, 96°; pulse, 148; skin cold and clammy; with great abdominal pain, severest in right inguinal region; mind clear; pinched and haggard countenance. Hypodermics of digitalis, atropine, and brandy were given, with warmth to the extremities.

Noon, same date, pulse 132; temperature, 95°; condition generally unchanged.

Two P. M., same date, condition about the same; 10 P. M., condition unchanged, except that temperature had gone down to 93°; pulse had gone up to 148.

16th.—At 5.30 A. M patient died.

This case is instructive inasmuch as it shows not only the difficulty sometimes experienced in diagnosis, but the great danger of the expectant plan of treatment.

CASE II. *Treated on the Expectant Plan.*—Looking over my notes, I find recorded there the following case:

N. G., aged nineteen years, native of this country; previous health good.

July 16, 1894, 1 P. M.—Took severe pain on right side of abdomen low down; 6 P. M., same date, I saw him. Pain right over the region of the appendix and nowhere else; temperature, 100.4°; pulse, 96. Diagnosis: acute appendicitis; ordered light flaxseed poultice, with salines every two hours until bowels moved.

17th.—Evacuation from bowels; pain almost gone. Temperature, 99.2°; pulse, good.

18th.—No pain, but some tenderness on deep pressure over the appendix. Temperature, normal; pulse, normal. Advised that patient keep quiet until this tenderness on deep pressure entirely disappeared; should it return, however, I should be informed.

In a few days he reported entire absence of tenderness on the deepest pressure. In this case I did not propose operation for the reason that all the symptoms rapidly subsided within the twelve hours instead of either increasing or remaining stationary. This patient has been under observation since July, 1894, and I am positive he has had no recurrent attack.

No sane surgeon would operate in such a case as this if we had any means of vouching for the result which took place. But for the one case that terminates in this way, fifty will recur, and some of the recurrences may prove fatal. That this was not a case of mistaken diagnosis I have but to say that I used here, as in Case I, the skill in diagnosis at my disposal, the same

which I used in a very large number of cases where diseased appendices were removed.

To tabulate or give in detail the many cases of appendicitis that have occurred in my service in two hospitals and in private practice would be but a repetition of what has been written many times before; nevertheless, they would speak loudly for early operation.

Case III. *Late Operation.*—John H. F., aged twenty-eight years, German; sent into my service at St. Mary's Hospital on January 31, 1896, with the following history and symptoms: sick for one week; on admission, temperature subnormal; pulse small, thready, and frequent; abdomen distended; abdominal muscles rigid and œdematous. Diagnosis: appendicitis with perforation. Oxygen and ether were administered as an anæsthetic; after a cautious preparation a rapid opening was made into the peritoneal cavity at the McBurney point, which was found filled with foul-smelling pus; a portion of a sloughed appendix, with a large concretion, found in the right iliac fossa; patient's condition bad; the abdominal cavity was flushed with warm Thiersch's solution. Perfect drainage was established, and the patient stimulated by every possible means. Notwithstanding all, he succumbed six hours later from sepsis.

Cases of this kind swell the mortality list in hospitals, and perhaps I voice the sentiment of hospital surgeons when I say that physicians do the operation a great injustice by sending patients to hospitals for operation in a moribund condition.

The surgeon of to-day must not only make a strong plea for early operation in appendicitis, but it is a moral obligation devolving upon him to use his influence in the consulting room to urge physicians to contrast with their patients the comparative safety of early removal of the appendix with the dangers of delay.

Case IV.—Mr. F. H., East New York, German, aged twenty-seven years. Diagnosis of appendicitis made immediately by his attending physician, Dr. Myer; sent into my service at St. Catherine's Hospital June 21, 1896, and operated on at once; an incision an inch in length was made through the integument and aponeurosis of the external oblique. The muscles of the internal oblique and transversalis were separated in the direction of their fibres (McBurney). Passing through the transversalis fascia and peritonæum, an inflamed appendix, five inches in length, was at once encountered lying along the inner side border of the cæcum. The mesocæcum was necessarily long. The left index finger, the one usually used for purposes of exploration, was gently passed over the appendix and upon its mesocæcum low down on its attachment.

On the lower and opposite side to the index finger I passed the flat bone handle of a blunt hook, and by pressing these extremities together I procured a firm hold. Then, with a gentle rotary movement, the appendix and its attachments with the cæcum were drawn through the small opening. The meso-appendix was tied off with catgut, the appendix itself removed, its base inverted and pushed into the cæcum. The serous coverings of cæcum were stitched over it by means of Lembert's suture. The peritonæum and transversalis fascia were brought together with a continuous fine catgut suture. The separated muscular fibres of the internal oblique and transversalis were allowed to fall together, while the aponeurosis of the external oblique, together with the integument, was closed by means of a cross suture of silkworm gut. The patient had no bad symptoms whatever. The silkworm sutures were removed on the sixth day, union complete. He left his bed on the eighth day and the hospital on the tenth day, resuming his ordinary duties.

Case V.—Miss K. O., aged seventeen, native; residence, Evergreen, Long Island; acute appendicitis.

June 22, 1896.—Twenty hours from the first symp-

tom was sent into my service at St. Catherine's Hospital and operated upon immediately.

The method used in Case IV was followed, except that the incision was three quarters of an inch. An inflamed appendix with necrosed mucous lining and an incipient slough about its centre was removed.

Left her bed on the eighth day and the hospital on the tenth day, perfectly well.

CASE VI.—Miss H. S., aged twenty-five years, native; sent into my service at St. Catherine's Hospital, June 23d, by Dr. Gerri, soon after the diagnosis was made. Immediate operation; same method as in Cases IV and V; patient up in eight days; left the hospital on the tenth day.

The cases recorded here are but a few of the many that might be mentioned. It is left to the reader to draw his own conclusions as to whether they argue for early operation or not.

In conclusion, I would state that I look upon appendicitis as a septic disease from the start, and I believe that the removal of the appendix as soon as the diagnosis is made will place the patient where no harm can befall him or her.

If we wait, within the abdomen is fostered one of the most dangerous and destructive diseases that mark the surgical calendar.

I will raise but one point in the ætiology of the disease, and this has been forced upon me by observation in my own cases as well as the cases of others—namely, many cases of appendicitis have followed rapidly upon attacks of acute intestinal catarrh. It is true that sometimes in fatal cases of acute diarrhœa no lesion has been found, but it is remarked by the best authorities that the hyperæmic membrane pales after death, as does the skin in scarlatina and erysipelas. The presence or ab-

sence, therefore, of hyperæmia is no proof of the existence or non-existence of inflammation.

There is nearly always, however, more or less turgescence, visible to the naked eye, present in the mucous and submucous tissues which have been the seat of catarrh, and this is nearly always found in the lower part of the ileum and the cæcum, the sigmoid flexure, as well as in other parts of the colon. This condition of hyperæmia is soon followed by acute œdema and increase in the cell elements, softening, and, in fine, all the requirements of a genuine inflammation. That this condition of the mucous lining of the ileum and cæcum, produced by an acute intestinal catarrh, should find its way to the mucous membrane of the appendix, thereby setting up an acute appendicitis, is not an unreasonable idea.

Thoroughness of technics, in surgical operations, now in vogue, prompted by bacteriological research, bordering upon perfection, renders early operation in appendicitis almost without danger. I am in accord with those who contend that appendicitis is a surgical disease and should be treated as such.

762 Willoughby Avenue.